Live COVID-19 Coding and Billing Q&A
May 6, 2020
Webinar FAQ Document

1. **Question** – We are a Critical Access Method II hospital with a provider-based clinic doing telehealth visits with the patient at home and the provider in the clinic. Do we bill, for example, a regular E/M code such as 99214 with modifier 95 or modifier GT? Also, can we also bill HCPCS code Q3014 with modifier PO or PN?

   Answer – As a Critical Access Hospital (CAH) Method II facility, you may submit the charge for the E/M level, such as 99214, *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family*, with modifier GT, *Via interactive audio and video telecommunication systems,*[1] to report the physician's professional service.

   If you request an exception to temporarily relocate to an off-campus location (which may be the patient's home) under the extraordinary circumstances policy outlined in the interim final rule, then you may submit the charges as you would have done had the patient come into your facility.[2] In this instance, you may also be using other modifiers and condition codes, such as Condition Code DR, *Disaster Related*, or modifier CR, *Catastrophe/Disaster Related*[3], etc. As a CAH, you are exempt from reporting modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, and modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*.[4]

   To apply for the extraordinary circumstance relocation exception, the following information should be sent to your Centers for Medicare & Medicaid Services (CMS) Regional Office within 120 days of the date that services are first provided in the new off-campus location(s): 1) The hospital's CMS Certification Number (CCN); 2) the address of the current provider-based department (PBD); 3) the address(es) of the relocated PBD(s); 4) the date which they began furnishing services at the new PBD(s); 5) a brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19; and 6) an attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.[5]

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[1] Transmittal R2095OTN, "Revisions to the Telehealth Billing Requirements for Distant Site Services", https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R2095OTN.pdf (June 20, 2018)

[2] Hospitals: CMS Flexibilities to Fight COVID-19, "CMS Hospital Without Walls Temporary Expansion Sites)". Page 5, https://www.cms.gov/files/document/covid-hospitals.pdf (April 29, 2020)

[3] "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing", page 10, https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (May 1, 2020)

[4] The Social Security Act, "Payment of Benefits, Section 1833(t)(21)", https://www.ssa.gov/OP_Home/ssact/title18/1833.htm

[5] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting

2. **Question** – How do we know if we are an excepted PBD and can use modifier PO and modifier PN?

   Answer – The information regarding your provider-based status would be available in the Provider Enrollment, Chain and Ownership System (PECOS). You may also contact your Medicare Administrative Contractor (MAC) to verify the status of your existing off-campus provider-based departments.[6] Modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be assigned when items and services are provided to registered patients of a hospital on-campus department or to registered patients of an excepted hospital off-campus provider-based department that has temporarily relocated under the extraordinary circumstances policy outlined in the interim final rule, CMS-5531-IFC. Modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be assigned when items and services are provided to registered patients of a hospital non-excepted off-campus provider-based department or when the hospital chooses not to pursue temporary relocation of the hospital department under the extraordinary circumstances policy.[7] Under the temporary relocation exception, hospitals may temporarily relocate a portion of each of their outpatient departments to multiple off-campus locations; these locations may include the patients' homes. Hospitals that opt to temporarily relocate their outpatient departments, or a portion of each department, under this exception must submit a request to their CMS Regional Office no later than 120 days following the date they begin providing services at one or more of these off-campus locations. The temporary relocation sites will be considered excepted off-campus provider-based departments of the hospital for the duration of the public health emergency and will be reimbursed for services provided using telecommunications technology at a rate which is equivalent to the rate that would be received if the services were provided during a face-to-face visit in the hospital outpatient department.

3. **Question** – Is modifier CR strictly for billing on the CMS-1500 for professional claims, or can it be used on both the facility claim (UB-04) and the professional claim (CMS-1500)?

   Answer – Modifier CR, *Catastrophe/Disaster Related,* is for use on both the CMS-1500 claim form for professional services and on the UB-04 facility claim form (CMS-1450). The modifier should be applied to all line items that are related to a COVID-19 waiver.[8]

4. **Question** – Can you clarify when to use Condition Code DR? Is that used only if you have an extended facility site?

Requirements for the Skilled Nursing Facility Quality Reporting Program", page 41, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[6] Medicare Provider-Supplier Enrollment, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index

[7] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-46, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[8] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 2, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

Answer – Condition code DR, *Disaster related,* is used when all items and services submitted on a claim are related to a COVID-19 waiver. If the patient's visit is impacted by COVID-19, then the condition code is appropriate. Examples provided by CMS include instances where a non-COVID-19 patient is housed in a separate unit to keep the patient from the COVID-19 positive population. Medical record documentation that explains how the patient's care was impacted by COVID-19 should be available.[9]

5. **Question** – We're looking for some clarification on modifier CS. CMS states modifier CS is appropriate for use with E/M levels and labs. Can we add it to chest x-rays if done as part of the workup for COVID-19? How about any other services during the Emergency Department visit, such as infusions and injections?

   Answer –The Families First Coronavirus Response Act (FFCRA) states that cost sharing is waived for "items and services furnished to an individual…that result in an order for or administration of…."[10] This verbiage is causing some confusion regarding which specific items and services should be provided without cost sharing. In the absence of further guidance and based on the wording of the law, however, it would be inappropriate to assign modifier CS to injections or infusions since those services would not result in an order for COVID-19 testing. CMS has stated that more information regarding modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* should be forthcoming; however, there has been no additional guidance provided yet.

6. **Question** – How can a hospital bill for physical therapy services via telehealth?

   Answer – Therapy services that are provided in a temporarily relocated off-campus provider-based department by the hospital's clinical staff using telecommunications technology would be billed as though they were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of participation, except for the conditions of participation that have temporarily been waived during the public health emergency. Also, if therapy services are not provided by clinical staff of the hospital, the hospital would not bill for these services. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus departments, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the Current Procedural Terminology (CPT®)[11] or HCPCS procedure code(s) that describes the service(s) provided. If the therapy services are normally provided in a non-excepted off-campus provider-based department or if the facility does not plan to seek an exception under the extraordinary circumstance relocation policy, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be appended to the procedure code(s). CMS has published a list of the outpatient therapy, counseling, and educational services that hospital clinical staff may furnish incident to a physician's service during the COVID-19 public health emergency.[12]

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[9] Pub. 100-04 Medicare Claims Processing Manual, "Chapter 38 Emergency Preparedness Fee-for-Service Guidance, Section 10 Use of the CR Modifier and DR Condition Code for Disaster/Emergency-Related Claims", page 2, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c38.pdf (July 25, 2014)

[10] "Families First Coronavirus Response Act", https://www.congress.gov/bill/116th-congress/house-bill/6201/text, page 134, Stat 201 (March 18, 2020)

[11] CPT® is a registered trademark of the American Medical Association. All rights reserved.

[12] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)

7. **Question** – Modifier QW may be applied to HCPCS code U0002 and CPT® code 87635. Do you need to be under a CLIA waiver in order to assign modifier QW?

   Answer – HCPCS code U0002, *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC,* and CPT® 87635, *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique,* were recently added to the list of tests that are waived through the Clinical Laboratory Improvement Amendment of 1988 (CLIA) amendments. In order to submit claims for the services, all providers must have a CLIA certificate. According to the CMS CLIA Fact Sheet, "CLIA mandates nearly all laboratories, including those in physician offices, must meet applicable Federal requirements and have a current CLIA certificate. CLIA applies to all entities providing clinical laboratory services including those that do not file Medicare test claims."[13]

8. **Question** – For facility-based licensed clinics providing telehealth services in a patient's home, do we need to apply for exception under the expansion program listing each patient's address in order to bill with modifier PO?

   Answer – Yes. In order to assign modifier PO, *Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments,* services must be provided from an excepted off-campus department of the hospital that has been temporarily relocated under the extraordinary circumstance relocation exception. This can be done by notifying your CMS Regional Office by email within 120 days of beginning to provide services in the new off-campus location(s) and including the following information: 1) The hospital's CMS Certification Number (CCN); 2) the address of the current provider-based department (PBD); 3) the address(es) of the relocated PBD(s); 4) the date which they began furnishing services at the new PBD(s); 5) a brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19; and 6) an attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.[14] Additionally, CMS reiterated during the CMS Office Hours call on May 7, 2020 that addresses must be provided for each of the locations (including patients' homes) to which the hospital outpatient department is temporarily relocating.

9. **Question** – For provider-based billing, can we split bill the facility fee on the UB-04 and report HCPCS code G0463 for our hospital outpatient department for the telehealth visit, along with billing Q3014 for the originating site fee?

   Answer – No. It would never be appropriate to report both a clinic visit and an originating site fee for the same patient. CMS stated during the CMS Office Hours calls of May 5, 2020 and May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[15] In other words, if the

[13] MLN® Fact Sheet, "CLIA Program and Medicare Laboratory Services", page 2, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CLIABrochure.pdf (October 2018)
[14] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 41, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)
[15] CMS Outreach and Education, "CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge. If, however, the hospital is not expending facility resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.

10. **Question** – Can providers bill for telehealth and/or telephone visits provided by pharmacists under "incident to" rules, per the most recent interim final rule? Can the pharmacist bill on a UB-04 for telehealth if the relocation requirements are met? Would phone calls be part of this as well?

    Answer – For hospital-based pharmacists, CMS is deferring to the state scope-of-practice regulations. If a pharmacist is functioning within state scope-of-practice regulations, does not contradict your state emergency or pandemic plans, is providing services incident to a physician/non-physician practitioner (NPP) order, and the service is not one that is covered under Medicare Part D, then the facility may submit services provided by a pharmacist on a UB-04 claim form. These must also meet other requirements, such as medical necessity and documentation.[16] Telephone services, such as CPT® codes 98966-98968 or HCPCS codes G2061-G2063, may be reported by auxiliary staff, which includes pharmacists.[17]

    If a pharmacist employed by the hospital provides services to patients in temporarily relocated off-campus provider-based departments (which may include patients' homes) using telecommunications technology in accordance with the extraordinary circumstances exception outlined in the interim final rule, CMS-5531-IFC, then these services may be submitted on the UB-04 as well.

11. **Question** – Can we bill therapy telehealth services if our PBD is an excepted off-campus PBD without requesting a relocation to the patients' homes?

    Answer – During the May 7, 2020 CMS Office Hours Call (which was after this webinar), CMS stated that you could append modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital,* without seeking temporary relocation of the hospital department under the extraordinary circumstances exception outlined in the interim final rule, CMS-5531-IFC[18] Procedures that are billed with modifier PN appended will be reimbursed at the Physician Fee Schedule (PFS)-equivalent rate, which is currently 40% of the Outpatient Prospective Payment System (OPPS) rate.

12. **Question** – Are pharmacists and genetic counselors considered approved providers for telehealth services?

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[16] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 25, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[17] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, Telehealth Evaluation and Management (E/M) Services, page 2, https://www.cms.gov/files/document/covid-final-ifc.pdf (March 18, 2020)

[18] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

Answer – Pharmacists and genetic counselors are not eligible to bill Medicare directly for their professional services on a CMS-1500 form. However, pharmacists and genetic counselors may provide services under the "incident to" provisions, in which case the physician or NPP would be able to bill for the professional services provided by the pharmacist or genetic counselor on the CMS-1500 form.

When pharmacists or genetic counselors are functioning as auxiliary staff of a hospital, CMS is deferring to the state scope-of-practice regulations. If the pharmacist or genetic counselor is functioning within state scope-of-practice regulations, does not contradict your state emergency or pandemic plans, is providing services incident to a physician/non-physician practitioner (NPP) order, and the service is not is covered under Medicare Part D, then the facility may bill for services that are provided by auxiliary staff on the UB-04 billing form. These must also meet other requirements, such as medical necessity and documentation.[19]

13. **Question** – For therapy and nutritional counseling services performed by facility-based clinics, do we bill the actual CPT® codes rather than Q3014?

    Answer – When therapy services are provided in a temporarily relocated off-campus provider-based department by the hospital's clinical staff using telecommunications technology, the therapy services would be billed as though they were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of participation, except for the conditions of participation that have temporarily been waived during the public health emergency. Also, if therapy services are not provided by clinical staff of the hospital, the hospital would not bill for these services. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus department, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the CPT® or HCPCS procedure code(s) that describes the service(s) provided. If the therapy services are normally provided in a non-excepted off-campus provider-based department or if the facility does not plan to seek an exception under the extraordinary circumstance relocation policy, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be appended to the procedure code(s). CMS has published a list of the outpatient therapy, counseling, and educational services that hospital clinical staff may furnish incident to a physician's service during the COVID-19 public health emergency.[20]

14. **Question** – When we send the email to the CMS Regional Office, does that mean we have to provide the patient's address as the NEW address?

    Answer – Yes. CMS reiterated during the CMS Office Hours call on May 7, 2020 that addresses must be provided for each of the locations to which the hospital outpatient department is temporarily relocating. The email may contain multiple addresses or may be in the form of a spreadsheet, but hospitals are reminded

[19] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 25, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[20] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)

that the information must be encrypted and should not include unnecessary protected health information (PHI), such as patient names.[21]

15. **Question** – Would a modifier be needed with Q3014 for an on-campus provider-based clinic?

    Answer – If the patient is physically located in the on-campus provider-based clinic, no modifier would be necessary when reporting Q3014, *Telehealth originating site facility fee*. Modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be assigned when items and services are provided to registered patients of a hospital on-campus department or to registered patients of an excepted hospital off-campus provider-based department that has temporarily relocated under the extraordinary circumstances exception outlined in the interim final rule, CMS-5531-IFC.

16. **Question** – Can a hospital PBD decide not to register all of the patient's homes they would treat, then bill with a modifier PN for the services provided to patients in their home?

    Answer – During the May 7, 2020 CMS Office Hours Call (which was after this webinar), CMS stated that you could append modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital,* without seeking a temporary relocation exception under the extraordinary circumstances policy.[22] Procedures that are billed with modifier PN appended will be reimbursed at the Physician Fee Schedule (PFS)-equivalent rate, which is currently 40% of the OPPS rate.

17. **Question** - How do I find out what revenue codes are appropriate to use with HCPCS code C9803?

    Answer – There has been no guidance published stating which specific revenue codes must be used. Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.[23]

18. **Question** - Is HCPCS code C9803 limited to laboratory personnel or can respiratory therapists also report this code?

    Answer - HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, is intended to be reported when hospital staff perform specimen collection for COVID-19 testing. There is no requirement that the collection be performed specifically by laboratory personnel.

19. **Question** – Is it true that we can bill HCPCS code G0463 when the physician provides a telehealth visit in a PBD? What is the difference between using the Q3014 and the G0463?

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[21] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[22] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[23] CMS Manual 100-04, "Medicare Claims Processing Manual", Chapter 4, Section 20.5, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf (Rev. February 4, 2020)

Answer – CMS stated during the CMS Office Hours calls of May 5, 2020 and May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[24] In other words, if the hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge, such as G0463, *Hospital outpatient clinic visit for assessment and management of a patient*. If, however, the hospital is not expending facility resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.[25]

20. **Question** – Do you have any advice for coding the COVID-19 lab tests in circumstances where the patient has been discharged before test results are available, and the physician doesn't mention why the test was ordered?

    Answer – The ICD-10-CM Official Coding Guidelines state that signs/symptoms associated with COVID-19 should be assigned when a definitive diagnosis has not been established. The guidelines further state that code Z20.828, *Contact with and (suspected) exposure to other viral communicable diseases,* should be assigned as an additional code for patients who have either an actual or a suspected contact with or exposure to someone who has COVID-19. If the lab test is subsequently found to be positive for COVID-19 infection, diagnosis code U07.1, *COVID-19,* should be assigned, even if the patient was asymptomatic.[26]

21. **Question** – Do we need to use modifier CS for every diagnosis code that is on the Centers for Disease Control (CDC) list, but not related to COVID?

    Answer – Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* is reported on the CPT® or HCPCS codes that result in the order of the COVID-19 test. Modifiers are not assigned to diagnosis codes.

22. **Question** – Are there coding options for inpatient services where telephone/video is not an option, but the provider is managing the patient via telephone conversations with other providers and floor/unit staff? For instance, the patient is in the Intensive Care Unit (ICU) and unresponsive, so is unable to utilize telehealth.

    Answer – In this instance, the facility's Intensive Care Unit (ICU) room & board rate will cover the facility's resources. If the physician is providing telehealth services to an inpatient, there are several CPT®/HCPCS codes that could be used to report the professional service charges for the physician depending upon the services that are provided. Unless provided otherwise, services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site, although there is a waiver for behavioral

[24] CMS Outreach and Education, "CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
[25] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
[26] ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020, Chapter 1, Section g, Subsection 1.f. and 1.g., https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

health counseling and educational services as long as the healthcare provider feels that services can be adequately performed using audio only.[27]

23. **Question** – We perform a telehealth service and determine the patient needs to be tested for COVID-19. The patient is sent to our urgent care location, who collects the sample for testing. For the telehealth visit, we bill our level of service with modifier 95. According to Medicare, for the collection, we should bill the 99211, which means we are billing two E/M fees on the same date. One visit is billed as telehealth with provider X and the other provider bills the 99211 at urgent care under the same tax ID number. Is there an exception made during this time to allow two E/M's?

    Answer – Effective January 1, 2020, CMS has suspended over 291,000 Procedure-to-Procedure (PTP) edits due to the COVID-19 public health emergency. This includes all of the PTP edits for the physicians that previously did not allow for reporting of CPT® code 99211, *Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services,* with other E/M codes when reported by the same provider for the same patient. The complete listing of suspended edits can be downloaded from the CMS website at shttps://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.

24. **Question** - Does the CS modifier apply to HCPCS code C9803?

    Answer – Yes. Modifier CS, *Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test,* should be appended to HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19]*, as the Ambulatory Payment Classification (APC) to which the code has been assigned does have a cost-sharing amount.[28] In order to waive the cost-sharing amount, as specified in the Families First Coronavirus Response Act (FFCRA), the modifier should be applied to the service.[29]

25. **Question** - What is the difference between HCPCS codes C9803 and G2023?

    Answer – HCPCS code G2023, *Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), any specimen source,* was created for use when a laboratory technician travels to a non-patient's home (Bill Type 014X) and collects the specimen for COVID-19 testing.[30]

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[27] Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19, page 1, https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf (April 29, 2020)

[28] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 196, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[29] "Families First Coronavirus Response Act", https://www.congress.gov/bill/116th-congress/house-bill/6201/text, page 134, Stat 201 (March 18, 2020)

[30] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, Telephone Evaluation and Management (E/M) Services, page 122, https://www.cms.gov/files/document/covid-final-ifc.pdf (March 18, 2020)

HCPCS code C9803, *Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) coronavirus disease [COVID-19,* was created for instances when a specimen is collected from a registered outpatient of a hospital, including specimen collection procedures that are performed at a temporarily relocated off-campus hospital departments or sites.[31]

26. **Question -** When do we expect CMS to update the exception so we don't need to file with every patient's address?

    Answer – CMS has given no indication at the current time that they will be providing an exception to this requirement. In fact, they may be unable to provide this exception as the law requires that hospitals may only bill for services provided at the hospital or at an authorized off-campus department of the hospital. The law further requires that addresses where services are provided must be on file with the CMS Regional Office. Hospitals that are seeking to temporarily relocate one or more of their departments under the extraordinary circumstance exception must provide the address(es) where services will be provided to meet this requirement of the existing law.

27. **Question -** For patients who test positive and are following up to be tested again, does the HCPCS code U0004 require a modifier to be reported to indicate we are testing again? If so, what modifier is appropriate for reporting?

    Answer – At this time, as long as medical necessity is met[32] and the tests are reported on different dates of service, then it would be appropriate to report HCPCS U0004, *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R,* without a modifier. There would be no National Correct Coding Initiative (NCCI) edit evoked.

28. **Question -** Can you clarify what qualifies for audio/video? For the PBDs, do these services have to be done using audio/visual equipment, or can they be audio (telephone) only?

    Answer – Audio/video would be a type of video chat functionality, and includes Facebook Messenger video chat, Google Hangouts, Zoom, or Skype. Services such as Facebook Live, Twitch or TikTok are public-facing and should not be used.[33] CMS has discovered that there are instances where video is unable to be used, and has increased the Relative Value Units (RVUs) for CPT® codes 99441-99443 which describe telephone

[31] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 195-196, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)
[32] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 22, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)
[33] "Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency," https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html, (March 30, 2020)

services. CMS has additionally identified several other services that may be performed using audio-only communication for certain situations.[34]

29. We have three different types of provider-based clinics: Off-site excepted clinics, offsite non-excepted clinics, and some located on-campus. How do we handle the Q3014 where the onsite clinic is concerned?

    Answer – If the patient is physically located in the on-campus hospital department, no modifier would be necessary when reporting Q3014, *Telehealth originating site facility fee*. However, if the on-campus provider-based clinic is providing services to a patient at a temporarily relocated department (which may be the patient's home) under the extraordinary circumstance exception outlined in the interim final rule, CMS-5531-IFC, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, should be assigned.[35] Under the temporary relocation exception, hospitals may temporarily relocate a portion of each of their outpatient departments to multiple off-campus locations; these locations may include the patients' homes.

30. In an acute hospital outpatient setting, we have ED physicians who want to do telehealth services for patients at home. If we send patient addresses to relocate the PBD with the CMS Regional Office, would you please confirm we would use our normal E/M levels with a modifier? Additionally, if we aren't approved for the relocation, you indicated we would need to adjust claims. What would we adjust on the claims, or would we just need to cancel the claims? What about other payers? Would we offer the same to them?

    Answer – CMS stated during the CMS Office Hours calls of May 5, 2020 and May 7, 2020 that they expect hospitals to bill the most appropriate code(s) for the services they are providing.[36] In other words, if the hospital is using facility resources above and beyond the costs associated with the telecommunications technology, including using hospital auxiliary staff to obtain patient history, record available vital signs, coordinate the discharge instructions, provide patient education, or similar tasks, then it may be appropriate to report an E/M visit charge. Remember that Emergency Department E/M levels are assigned based on hospital-specific criteria, and the level assigned should directly correlate with the facility's resource utilization. If, however, the hospital is not expending facility resources outside of the resources utilized to initiate the telehealth visit, it is likely more appropriate to report HCPCS code Q3014, *Telehealth originating site facility fee*, to cover the costs associated with providing the visit utilizing telecommunications technology.[37] The facility would submit codes for the services provided using modifier PO, *Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments*, if you plan to temporarily relocate under the extraordinary circumstances exception as outlined in the interim final rule, CMS-5531-IFC. If your exception is

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[34] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 137-141, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[35] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-46, available at https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[36] CMS Outreach and Education, "CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

[37] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," available here: https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

denied by the CMS Regional Office, then you will be required to resubmit the claims with modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, and they will be reprocessed at the PFS-equivalent rate, which is currently 40% of the OPPS rate..[38]

These policies apply specifically to services provided to Medicare beneficiaries. Each individual payor may have their own guidelines and reimbursement policies related to telehealth services. It will likely be necessary to check with each payor regarding their specific policies to ensure accurate reimbursement for these services.

31. If the hospital-based outpatient therapy physician is in the clinic at the hospital and remotely connects with the patient at home, is it correct that only the physician can bill for the telehealth visit on the professional claim form (CMS-1500), and there is no hospital billing since the patient is not on-site? Or are you stating that the facility can bill for G0463 in a split billing situation?

    Answer – When the physician is in the clinic and provides a telehealth visit with a patient who is at home, the service is only reportable by the physician on the professional claim form (CMS-1500) because telehealth services are professional services only. [39]

    When therapy services are provided in a temporarily relocated off-campus provider-based department (which may be the patient's home) by the hospital's clinical staff using telecommunications technology, the therapy services would be billed as though they were provided face-to-face. Note that services must be provided in accordance with the appropriate level of supervision and the hospital must ensure the location(s) meet all of the conditions of participation, except for the conditions of participation that have temporarily been waived during the public health emergency. Also, if therapy services are not provided by clinical staff of the hospital, the hospital would not bill for these services. If the hospital plans to seek an exception under the extraordinary circumstance relocation policy for their on-campus or excepted off-campus department, modifier PO, *Services, procedure and/or surgeries provided at off-campus provider-based outpatient departments*, would be appended to the CPT® or HCPCS procedure code(s) that describes the service(s) provided. If the therapy services are normally provided in a non-excepted off-campus provider-based department or if the facility does not plan to seek an exception under the extraordinary circumstance relocation policy, modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, would be appended to the procedure code(s). CMS has published a list of the outpatient therapy, counseling, and educational services that hospital clinical staff may furnish incident to a physician's service during the COVID-19 public health emergency.[40]

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[38] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", pages 37-39, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[39] "Medicare Telehealth Frequently Asked Questions, Question #13, https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf (March 17, 2020)

[40] List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC, https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers (April 30, 2020)

32. For Behavioral Health Partial Hospitalization Program telehealth group therapy, does CMS require the facility to be certified by their state as a PHP, or can the facility be certified as an Intensive Outpatient Program provider in order to provide services during the pandemic?

    Answer – Partial Hospitalization Program (PHP) services by definition must be furnished by a hospital or by a community mental health center (CMHC).[41] That being said, mental health providers would fall under the category of auxiliary personnel who may provide services incident to a physician's, NPP's or clinical psychologist's plan of care, as long as the supervision levels are appropriate, the provider is functioning under their state's scope-of-practice laws, and are not in conflict with the state's emergency preparedness or pandemic regulations.[42]

33. If the patient is in the ED for trauma, needs surgery, and the COVID-19 test is performed, is a CS modifier appropriate since the ED E/M is more about the trauma?

    Answer – This was (somewhat) addressed at the May 7, 2020 CMS Office Hours call, and the CMS subject matter expert stated that there is no national policy at this time and providers should check with their Medicare Administrative Contractor (MAC).[43]

34. If HCPCS code Q3014 represents the originating site fee, and the originating site per CMS is the location of the patient at the time the service is furnished, how would a hospital bill for Q3014 when a provider is using hospital equipment to contact a patient at home? I'm confused on how that would make us the "originating site".

    Answer – CMS is allowing hospitals to temporarily relocate departments to off-campus sites, which may include the patient's home under the extraordinary circumstance exception. The hospital department may temporarily relocate to multiple locations (and therefore to multiple patients' homes) during the COVID-19 public health emergency. Essentially, CMS is using the extraordinary circumstances exception to allow hospitals to provide services to patients in their home and be reimbursed for their costs. Each location temporarily becomes part of your facility, allowing hospitals to bill for the originating site fee and other services that are provided via telecommunications technology, even though the services may be provided in the patient's home. In order to take advantage of this exception, hospitals should apply for an extraordinary circumstance relocation exception by notifying their CMS Regional Office by email within 120 days of beginning to provide services in the new off-campus location(s) and include the following information: 1) The hospital's CMS Certification Number (CCN); 2) the address of the current provider-based department (PBD); 3) the address(es) of the relocated PBD(s); 4) the date which they began furnishing services at the new PBD(s); 5) a brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19;

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[41] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 49, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[42] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 20, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)

[43] CMS Outreach and Education, "Thursday, May 7, 2020 CMS Office Hours," https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

and 6) an attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.[44]

[44] CMS-5531-IFC, "Medicare and Medicaid Programs, Basic health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program", page 41, https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf (April 30, 2020)